Understanding and Coping with Bipolar Illness

A Survival Manual for Families

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University of Pittsburgh Health Systems

Services for Teens at Risk

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Forward

"We would like to express our gratitude to the patients and family members for their contributions to this manual. In addition, we wish to thank Kay Jamison, M.D. for her thoughtful review of the manual, and her insightful suggestions for enhancing it as a resource for patients, families, and health care professionals."
INTRODUCTION TO THIS MANUAL

Services for Teens at Risk (STAR-CENTER) is a specialty research program designed to address the increasing problems related to adolescent suicide and mood disorders. Our program was founded in 1986, by David Brent, M.D., Chief of Child Psychiatry and Director of STAR-Center at Western Psychiatric Institute & Clinic of the University of Pittsburgh Medical Center and Mary Margaret Kerr, Ed.D. Director of STAR-Center Outreach, Western Psychiatric Institute & Clinic, University of Pittsburgh Medical Center. STAR-CENTER is funded by the Commonwealth Pennsylvania General Assembly with the primary mission, the prevention of adolescent suicide.

The Stanley Center for the Innovative Treatment of Bipolar Disorder, is a collaborative effort of Western Psychiatric Institute & Clinic at the University of Pittsburgh Medical Center and with the support of the Alliance for the Mentally Ill (AMI) of Southwestern Pennsylvania, was established to help treat people with Bipolar Disorder. The Stanley Center is funded by a grant from the Theodore and Vada Stanley Foundation and is directed by David Kupfer M.D., Chairman of Psychiatry at the University of Pittsburgh School of Medicine, and Ellen Frank, Ph.D., Professor of Psychiatry and Psychology, University of Pittsburgh School of Medicine. The Stanley Center’s mission is to promote the development of comprehensive and innovative treatments for Bipolar Disorder.

Most recently, the Stanley Center has expanded its mission to include a Pediatric Bipolar Clinic, the Child and Adolescent Bipolar Services (CABS) directed by Boris Birmaher, MD. The main goals of this program are to assess, treat and follow-up children and adolescents with Bipolar Disorders and psychiatric disorders with symptoms that suggest the existence of a Bipolar Disorder.

The CABS and STAR-Center realize how essential it is to work as partners with families in a collaborative effort to help gain a better understanding of Bipolar Disorder. Families have found it extremely helpful to learn accurate, updated information about their family member’s illness.

We have learned from many families that it can be extremely difficult to live with a family member who is experiencing a mood disorder like Bipolar Disorder. We have come to know that similarly to when a family has someone afflicted with a serious physical illness, emotional illness affects the whole family. This manual was written for patients and their families.

The information in this manual primarily focuses on adolescents and children, however the information is also applicable for adults. We have similar manuals that focus on Major Depression and Anxiety Disorders. Please let us know if you would like additional information. We hope you find this information helpful, and we look forward to working with you.
INTRODUCTION TO BIPOLAR DISORDER (Manic-Depression)

What is Bipolar Disorder?

Bipolar Disorder is an episodic psychiatric illness the key features of which are severe mood swings from one extreme (mania) to the other extreme (depression) with associated symptoms such as decreased need for sleep, irritability, impulsivity and excessive involvement in potentially harmful behaviors. These mood swings and associated symptoms are not similar to the normal mood changes that any of us may experience from time to time. The person suffering from Bipolar Disorder, while in an acute episode of mania or depression, does not function as usual and impairment occurs in all domains of life, including interpersonal, social, academic, and occupational. Bipolar Disorder symptoms, course, severity, and response to treatment differ from individual to individual.

There are varying degrees and types of Bipolar Disorder. Throughout this manual we will describe and differentiate the various types: Bipolar Disorder I (alternating episodes of Mania & Major Depression); Bipolar II (alternating episodes of Hypomania - or milder symptoms of Mania, as well as full episodes of Major Depression); Mixed States, Rapid Cycling, and Cyclothymia (chronic episodes of mild depression & Hypomania).

Why is the illness referred to as "Bipolar"?

The term "Bipolar" is a term used to capture the cyclic nature of the illness. "Bi" (meaning two) and "polar" (meaning extreme opposites), illustrate that in part, the illness is an impairment in the brain’s ability to modulate moods. Instead, the person afflicted with Bipolar Disorder experiences prominent fluctuations in mood swings. The extreme "highs" (mania) are manifested by severe irritability and/or elation and associated behavior changes, and typically last for a few days up to a period of weeks. These "highs" alternate with severe and unpredictable mood swings to the opposite "pole" (depression), which may last weeks to months. During this period of transition between these opposite "poles," the afflicted person can be quite unstable and at high risk for unfavorable consequences. The amount of time it takes to "cycle" from one "pole" to another also varies. An example would be to think of "mania" as the "North Pole" and depression as the "South Pole." The mood swings can be "sporadic" (e.g., once every 1-2 years OR "rapid" mood swings (e.g., changing daily). The frequent "ups and downs" are described by some as feeling like "riding a mood roller coaster." Sometimes, both manic and depressive symptoms may coexist simultaneously. This is known as a "mixed state", and is more difficult to treat. A "mixed state" is a period of time (nearly everyday, lasting at
least one week) in which the individual is experiencing symptoms of both a Manic Episode and a Major Depressive Episode.

Again, it is not unusual for any of us to have occasional mood "swings", however the mood swings for individuals suffering from Bipolar Disorder are extreme, unpredictable and cause significant impairment for the individual and often for the entire family.

**Myths about the illness - Can children and adolescents suffer from this illness? Could it just be moodiness?**

Children and adolescents can and do suffer from this illness. Recent research indicates that up to .4 % of children and 1% of adolescents may have Bipolar Disorder and more may have milder, but still significant mood swings.

For children and adolescents experiencing symptoms of Bipolar Disorder, initially the symptoms such as irritability and unusual behavior, can be mistaken as severe behavior problems, hyperactivity, and or drug and alcohol abuse. What makes the diagnosis so challenging is that often these problems co-occur with Bipolar Disorder. Symptoms of Bipolar Disorder are not just "moodiness." The change in mood and behavior are sudden, extreme, and drastic. The changes in behavior often lead families to suspect the cause to be drug and or alcohol related, only to later discover their child/teen is experiencing symptoms of a major mood disorder, such as Bipolar Disorder. However, it is not unusual for Bipolar adolescents to use alcohol and or drugs, which serve to further complicate a very serious illness.

Additionally, due to extreme irritability/anger, the child/teen may first experience difficulties within the school/community. The social, familial and academic impairment for the child/adolescent may be severe.
EPISODES OF MANIA

As mentioned earlier, Bipolar Disorder (Bipolar I) is a cyclic psychiatric condition in which the individual afflicted experiences episodes of mania alternating with episodes of depression. Let’s first look at the symptoms of Mania.

A Manic Episode is a distinct period during which the individual experiences abnormally elevated and "high", expansive or irritable mood. Manic episodes usually begin suddenly and symptoms increase over a few days. For adults to be called "manic," this period of abnormal mood must last at least one week but in children may last days or sometimes hours, but usually are much briefer than depressive episodes.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), to meet criteria for a diagnosis of Mania, in addition to the expansive or elevated mood, the child/teen must also present with at least three of the additional following symptoms: inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for negative consequences.

If the mood is irritable (rather than elevated or expansive), at least four other symptoms must be present. The disturbance must be severe to the point of causing significant impairment in social or occupational functioning or require hospitalization.

Symptoms

Let's take a closer look at the symptoms for a Manic Episode, beginning with elevated, expansive or irritable mood. The elevated mood of a Manic Episode may be experienced as euphoric, "on top of the world," unusually good, or "high." It is recognized as excessive and out of context by those who know the person well. It is clearly different from the normal happy mood someone would experience in response to a joyful experience such as going on vacation or being honored at a surprise birthday party. The elevated, expansive or irritable mood is more exaggerated and pervasive than the usual silliness or irritability observed in a child and often these symptoms are out of context, in other words, in inappropriate places. The expansive quality of the mood is characterized by excessive and indiscriminate enthusiasm ("giddy," "silly," "sparky") to seek out interpersonal, sexual or occupational interactions. For example, the person may start extensive personal conversations with complete strangers in public places, like while riding the bus. The predominant mood may be irritability. "Lability" of mood (mood alternates between euphoric and irritable) is also very common.

Exaggerated self-esteem is most usually present, ranging from increased self-confidence to noticeable grandiosity, that could become delusional. For example,
despite lack of a special talent, the individual may believe s/he will be the star of an 
upcoming television show or begin writing a novel or play for publication.

**Decreased need for sleep** is another common symptom evident during episodes of Mania. The person may wake up several hours earlier than usual and feel 
completely full of energy. The person may experience **excessive energy** and go 
for days without sleeping, and continue to feel rested and energetic. This may lead 
to a viscous cycle, since sleep deprivation can precipitate or worsen mania, and 
even lead to psychosis. This points to the importance of the maintenance of regular 
sleep patterns for the person with Bipolar Disorder.

The individual experiencing a Manic episode may also experience **rapid speech** 
which may be pressured, loud, fast and difficult to interrupt. They may ramble or 
change very quickly from one unrelated topic to another (flight of ideas). The 
person may talk nonstop, sometimes for hours with little regard for others. 
Inappropriate joking and story telling sometimes characterize speech. The 
individual may become more dramatic than usual. If the person’s mood is irritable, 
they may experience many sudden angry outbursts.

The individual may also experience **racing thoughts**, often at a faster pace than 
they can keep up. Adolescents who experience racing thoughts describe it as if a 
"pinball/video game" is playing in their heads and they can not keep up with the 
many thoughts "pinging" inside their head. This symptom may be extremely 
distressful and uncomfortable.

**Distractibility** is evident for the individual in a Manic Episode. There may be a 
reduced **ability to screen out irrelevant material**. This symptom often creates 
impairment for the individual at school and or work, as they cannot focus on the task 
at hand. The individual is easily distracted and impulsive.

The **increase in goal-directed activity** refers to the excessive planning and 
involvement in multiple activities, more so than usual for the individual. The 
individual may suddenly begin joining multiple school clubs and organizations and 
volunteering for many responsibilities with no regard to previous commitments. 
Increased sexual interest and or behavior may be evident. Without awareness of 
the inappropriateness, the individual may telephone friends or strangers at all hours 
of the night or write several lists of their excessive thoughts and ideas.

Excessive optimism, grandiosity, impulsivity and **poor judgment** may lead to unwise 
involvement in activities completely unusual and out of character for the person, 
such as impulsive spending or giving away excessive amounts of money, gambling, 
intrusiveness, increased telephone calls at all hours of night, reckless driving, 
accepting dangerous dares/challenges and sexual promiscuity. Some individuals 
may become **physically assultive** or in extreme situations, **homicidal and/or 
suicidal**.

**Psychotic symptoms** may or may not be present for an individual with Bipolar 
Disorder. Psychotic symptoms refer to symptoms such as hallucinations, paranoia 
and delusions. The delusions are often of a grandiose variety - such as when the
manic person claims to have special talents or a messianic mission (going to save the world, etc.).

In summary, Bipolar Disorder (I) is an illness characterized by episodes of Mania alternating with episodes of Major Depression. Some people just have episodes of Mania, but most have episodes of both.
DESCRIPTIONS AND GRAPHS

The following descriptions and graphs will illustrate Bipolar Disorder, Manic Episode; Hypomania; Mixed State; Rapid Cycling and Major Depression (Unipolar Disorder).

Bipolar Disorder

"Nancy" is a 15 years old girl with no previous history of difficulties at school, home or with peers. She had several friends, was very active in extracurricular activities and an honor student. Even though she was popular with her peers, she was seen as “quiet and reserved” and often preferred spending time alone reading or studying.

During a family vacation, "Nancy" suddenly became extremely outgoing and “silly” with strangers. Her mood continued to become very elated and increasingly irritable. She began introducing herself to strangers and behaved in a very unusual and provocative manner. She did not want to go to bed that night and instead stayed up throughout the night calling and emailing all her friends. By the next day, having had no sleep at all, she continued to engage in very unusual behavior. She became severely irritable and aggressive with family members. While in a restaurant with her family, she became aggressive with the waiter. She stomped out of the restaurant and returned to the family's cottage. A few minutes later, as her family prepared to leave the restaurant to check on her, "Nancy" returned screaming and running naked through the restaurant. (This was "Nancy's" first manic episode; she was later hospitalized due to manic symptoms including homicidal threats; soon after hospitalization, she became severely depressed and suicidal).

Bipolar Disorder

Manic and Depressive Episodes

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<th>Severe Mania</th>
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<tr>
<td>Moderate Mania</td>
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<tr>
<td>Mild Mania</td>
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<td>Normal Mood</td>
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<td>Mild Depression</td>
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<td>Moderate Depression</td>
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<tr>
<td>Severe Depression</td>
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Hypomania

“Barry” experiences periods of days to weeks in which he becomes clearly more productive and self-confident. He feels “on top of the world” however no major changes in his life have occurred. His close friends and family members clearly notice that he is different than his “usual self”. During these times, “Barry” is more active, sleeps less and thinks more rapidly and creatively. He is more optimistic however at times his mood is more irritable than usual. His greater self-confidence and optimism lead him to try new things that otherwise he would not. He experiences no major difficulties during these periods of time, however these episodes of hypomania alternate with periods of time in which he has no symptoms (normal functioning) and episodes of extreme depression and impairment (Major Depression).
Mixed State

"Cindy" is a 17-year-old teenager who at the age of 15 was diagnosed as having Bipolar Disorder. She was hospitalized during her first episode of mania and was effectively treated with medications and therapy.

Over the past few weeks she has been inconsistent with her treatment. She often skips medications and misses therapy appointments. Despite her parents concerns, "Cindy" reports she is "feeling fine" and subsequently refuses to attend treatment regularly. Over the past few days she appears energized and optimistic however her parents are worried due to her increased irritability and insomnia. Her parents notice "Cindy" exhibits simultaneous excited silly and irritable mood. However, at the same time she complains of feeling sad and suicidal. Within a few days, she began experiencing extreme fatigue and desire to rest but due to "racing thoughts" she was unable to put her mind to rest or to slow down from her activities. She reported feeling "driven" to continue more and more activities, yet was feeling more and more fatigued and extreme sadness. She was tearful and elated all within the same interaction.
Rapid Cycling

"Mary" is an 11-year old girl who for the last 2 years has experienced several episodes of depression manifested by severe sadness, tiredness, insomnia, lack of concentration and increased appetite. These episodes last in average 2 weeks and affect her academic and social life. In addition to these episodes of depression, "Mary" has been experiencing 5 hours to one week episodes where she is very happy, silly, agitated, energetic, talkative and socially hyper sexual. Sometimes these episodes of depression and mania can alternate in the same week or day.
Major Depression

"Aaron" is a 16-year old boy who has no previous history of mood problems. A few months ago, "Aaron's" parents noticed that he became increasingly irritable and angry which was very out of character for him. He began to withdraw from his family and at times, also from his friends. He stayed in his room much of the time and there were times his mother thought she smelled marijuana coming from his room. "Aaron's" grades started to drop and he complained that he couldn't concentrate on schoolwork anymore and really didn't care about school. He stopped participating on the Debate Team, got fired from his part time job for not showing up and seemed to lose interest in other activities as well. His sleep habits changed. He was frequently up most of the nights and often overslept, making him late for school. His rarely ate meals and appeared to have lost weight. Frequently he would quickly become angry over something small and make statements like: "I can't take this anymore. I wish I were never born". "Aaron's" parents report these changes in his mood and behavior have been progressive over the last few months and that they have never seen him like this before.

Major Depression (Unipolar Disorder)
EPISODES OF MAJOR DEPRESSION

Symptoms

According to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, DSM-IV), an episode of Major Depression is defined as a disorder with at least five of the following symptoms. These symptoms have been present during the same two-week period and represent a change from previous functioning. At least one of the following symptoms:

- **depressed mood - sad, angry, irritable or bored** most of the day, nearly every day indicated by subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents irritability is more prominent than a sad mood. Irritability/anger may be manifested by a "short fuse," feeling on edge, easily annoyed, "grouchy" and/or;

- **Loss or lower interest or pleasure in all or almost all activities** most of the day, nearly every day (as indicated either by subjective account or observation made by others). Feeling uninterested in things that were previously of interest. Feeling bored a lot and a loss of ability to experience pleasure, enjoy and have fun during activities. May appear to be "going through the motions."

In addition, to be diagnosed with an episode of Major Depression, the individual must have for two weeks or more, at least 4 of the following:

- **Significant weight loss or weight gain** when not dieting (e.g., more that 5% of body weight in a month), or decrease (eating less, not feeling hungry) or increase in appetite as compared to usual (feeling hungry all of the time) nearly every day. **Note:** in children, consider failure to make expected weight gain.

- **Changes in sleep patterns** - Initial insomnia (difficulty falling asleep), or hypersomnia (sleeping more hours than usual). Other sleep difficulties may include: middle insomnia (difficulty staying asleep), terminal insomnia (waking up early), circadian reversal (for example, goes to bed no earlier than 4 a.m. and wakes up at noon).

- **Psychomotor agitation** - Refers to feeling restless, inability to sit still, pacing, fidgeting; OR **Psychomotor retardation** - Slowing down of body movements, reacting slowly, slowed speech, decreased amount of speech.
- **Changes in energy** - Fatigue or loss of energy. Frequent complaints of being tired, even after sleeping. Spending more time resting.

- **Feelings of worthlessness or excessive or inappropriate guilt.**

- **Diminished ability to think or concentrate or indecisiveness.** Symptoms include: difficulty paying attention, diminished ability to concentrate, forgetfulness, slowed thinking, taking longer to do things, and decreased grades or work performance.

- **Suicidal ideation and behavior** - Preoccupation with thoughts of death or suicide. Actual suicide attempts.

- **Other depressive symptoms often evident:**

  - **Changes in socializing patterns** - Less contact/involvement with family and friends compared to usual, preferring to be alone, avoiding social contacts, not going out to activities, and avoiding phone calls.

  - **Hopelessness and discouragement** - Negative outlook toward the future regarding life and current problems. Feeling like giving up on things. Feeling like he/she can't be helped. Lack of care of personal appearance and poor self-esteem. Feeling like he/she will always feel this way. Hopelessness is essential to evaluate as it is linked with suicidality.

The symptoms of depression usually develop over a course of days to weeks. The duration of a depressive episode varies for each individual and may last from days to months. For individuals with Bipolar Disorder, the depressive episodes nearly always last significantly longer than the manic or hypomanic episodes.

Similar to the manic episodes, the severity of depressive symptoms varies for each individual. Depressive symptoms can range from mild physical and mental slowing to severe depressive stupor (may appear dazed or in a trance). Disturbance of sleep is almost always evident and sometimes precedes all other depressive symptoms. Delusions and hallucinations often occur in Bipolar depression, but are less frequent than psychotic symptoms in mania episodes.
TYPES OF BIPOLAR DISORDER

Bipolar I Disorder (Mania & Major Depression)

As discussed in the above section on page 5, the essential feature of Bipolar I Disorder is the occurrence of one or more Manic episodes or Mixed episodes alternating with one or more Major Depressive episodes.

More than 90% of individuals, who have a single episode of Mania, will go on to have future episodes. According to the Diagnostic & Statistical Manual of Mental Disorders (DSM-IV), 60-70% of Manic Episodes occurs immediately before or after a Major Depressive Episode.

Bipolar II Disorder (Hypomania & Major Depression)

Manic symptoms can range from moderate to severe. When the individual is experiencing only mild to moderate level of symptoms, with little to no impairment in functioning, this is referred to as "Hypomania." This condition of Hypomania and episodes of Major Depression is commonly referred to as Bipolar II. A stranger may not recognize the Hypomanic episode as a problem, but those who are close to the individual may see the behavior as excessive and unusual. In Hypomania, the less severe form of mania, mood, cognitive and behavioral changes is generally moderate and may or may not result in serious problems for the individual.

The mood in Hypomania is usually lively, self-confident, and elevated, but with underlying irritability. In order to diagnose hypomania, there must be a distinct period of persistently elevated or irritable mood that last at least four days that is clearly different from the usual mood. In this condition, the mood may be very quick to change. Activity and behavior are greatly increased. Creativity and productivity may be enhanced for the hypomanic individual, which may be the reason that some individuals refuse treatment because they enjoy this type of mood and productivity. Individuals may become more so than usual, interpersonally aggressive. These changes are clearly different from the individual's usual way of functioning. Hypomanic episodes may last from hours to months. Usually, the Hypomanic episode is preceded by or followed by an episode of Major Depression. The Hypomanic episodes are usually shorter in duration than the Major Depressive episodes.

Studies in adults indicate that approximately 5-15% of individuals with Bipolar II (Hypomania and Major Depression) will go on to develop a full blown episode of Mania and Major Depression which would change the diagnostic classification to Bipolar I Disorder. However no similar studies have yet been performed in children and adolescents.
Mixed States

Sometimes, particularly in young children and adolescents, both manic and depressive symptoms may coexist simultaneously. This is known as a "mixed state," and is more difficult to treat, and may be related to simultaneous substance abuse. A "mixed state" is a period of time (nearly everyday, lasting at least one week) in which the individual is experiencing symptoms of both a Manic Episode and a Major Depressive Episode. The individual experiences simultaneous moods (sadness, irritability, and euphoria) accompanied by symptoms of a Manic Episode and a Depressive Episode. The mood disturbance is severe and causes major impairment in functioning at school, work or in usual social activities or relationships with others.

"Mixed states" appear to be more common in younger individuals. Mixed states can emerge from a Manic episode or from a Major Depressive episode. The individual suffering of a mixed state episode usually looks confused, agitated and s/he can laugh and cry at the same time. This condition has been associated with greater vulnerability to suicide.

Rapid Cycling

Sometimes episodes of mania and depression alternate very quickly. This is referred to as "rapid cycling" and is also difficult to treat. Often both "mixed states" and "rapid cycling" are associated and perhaps triggered by coexisting substance abuse. Approximately, 5-15% of adults with Bipolar Disorder have rapid cycling (four or more) mood disordered episodes (Major Depression, Manic, Mixed, or Hypomanic) that occur within a given year. Rapid cycling can occur as often as daily. When cycling is very rapid it approaches "mixed state". Rapid cycling appears to be more common in children and adolescents than in adults. A rapid cycling pattern is associated with a poorer prognosis.

Psychosis

Psychotic symptoms may or may not be present for an individual with Bipolar Disorder. Psychotic symptoms refer to symptoms in which the individual experiences hallucinations (person sees or hears things that are not actually present) and or delusions (a false belief that is based on incorrect inference about reality).

Most commonly, the content of the delusions or hallucinations is consistent with either the manic or depressive themes. This would be referred to as "mood congruent psychotic features." For example, God's voice may be heard explaining that the person has a special mission. Less commonly, the content of the hallucinations or delusions has no apparent relationship or connection to the manic or depressive themes. This would be referred to as "mood-incongruent psychotic..."
features." An example would be, the individual experiences delusions of control (i.e. ones' actions are under outside control). These features are associated with a poorer prognosis.

Individuals with Bipolar Disorder may develop psychotic symptoms after days or weeks in what was previously a nonpsychotic Manic or Mixed Episode. When an individual has Manic Episodes with psychotic features, subsequent Manic Episodes are more likely to have psychotic features. Incomplete recovery between episodes is more common when psychotic features accompany the current episode.

Cyclothymia

This condition is characterized by a chronic mood disturbance of at least two years duration, involving numerous periods of mild depression and hypomania (mild manic symptoms). Symptoms are not as severe or long lasting as symptoms in a manic or a depressive episode. In Cyclothymic Disorder the depression and hypomanic periods may be separated by normal moods lasting for months at a time or the two types of mood may be occurring at the same time or may alternate with each other. In a Cyclothymic Disorder there are no psychotic symptoms. In children and adolescents, Cyclothymic Disorder may progress to full-blown Bipolar Disorder, although the exact risk of progression is not known.

CONSEQUENCES/FUNCTIONAL IMPAIRMENT

In manic episodes, there is usually a marked impairment in social and academic/occupational functioning for the individual. Due to the person's agitation and poor judgment, family members are often required to protect the person from negative consequences of his/her actions. During a manic episode, an individual may engage in extreme behaviors that normally would never be considered, such as spending money impulsively, taking unplanned trips, making unrealistic financial or time commitments, becoming increasingly aggressive, engaging in promiscuous sexual behavior, and making poor social and academic/occupational judgments. These actions may create major stress and serious consequences for the individual and the family.

For some individuals with Bipolar Disorder, no symptoms or impairment marks the intervals between episodes in social functioning. Between episodes they return to their normal level of functioning. Other individuals may have subtler onset of episodes as well as less complete recovery from symptoms. Approximately 20-30% continue to experience mood lability and interpersonal or academic/occupational difficulties. Additional functional impairment may occur for the person who experiences psychotic features during their episode.

During depressive episodes, there is always some decline in social and occupational functioning for the depressed individual. If severe impairment occurs,
the person may not be able to take care of his or her own personal needs. Decreased ability to function in specific roles of spouse, parent, employee, student, family member, and friend may occur. The depressed individual will experience decreased effectiveness and interest in their roles. They may avoid responsibilities, including refusing to help with the household, refusing to make decisions, not doing homework, and not attending school or work.

There is evidence that children who were previously depressed but then "remit" continue to show functional impairment, even after symptoms have improved. Children who have been depressed from an early age, often experience social delays/deficits that may continue to be evident in adolescence and adulthood. When Bipolar Disorder is accompanied by other psychiatric disorders the functional impairment may be severe.

COMORBIDITY (CO-EXISTING CONDITIONS)

Some individuals diagnosed with a Bipolar Disorder also meet full criteria for an additional, co-existing condition such as Attention-Deficit/Hyperactivity Disorder, Panic Disorder, Social Phobia, Generalized Anxiety, Substance-Related Disorders (drugs/alcohol), Oppositional Defiant Disorder, Conduct Disorder or Eating Disorders (Anorexia or Bulimia). Recent studies have indicated that co-existing conditions may affect the individual's recovery and suggest the importance of treating the Bipolar Disorder as well as the other co-existing psychiatric disorders. Please refer to the following section, Differential Diagnosis, for information about other disorders.

DIFFERENTIAL DIAGNOSES

Up until this point we have discussed both components of Bipolar Disorder the episodes of Mania and Major Depression. Throughout this section we will discuss other diagnoses that may be confused with the diagnosis of Bipolar Disorder.

"Unipolar" Major Depression (Major Depression with no Mania/Hypomania)

"Unipolar" ("one pole") Major Depression is a psychiatric illness in which the individual experiences episode(s) Major Depression without episodes of Mania, Hypomania or Mixed States (see page 15 for symptoms of Major Depression). Some people have only one episode of Major Depression, referred to as Unipolar Major Depression, Single Episode. However, if the individual experiences more
than one depressive episode, the condition is referred to as Unipolar Major Depression, Recurrent. Regardless of number of episodes, the individual who experiences depression without episodes of mania or hypomania will be classified as having a "Unipolar" Major Depression changing the classification of their illness to Bipolar Disorder.

Approximately 15% to 30% of children and adolescents diagnosed with Major Depression may go onto later have an episode of mania, therefore is Bipolar Disorder.

**Major Depression, With Psychosis**

When delusions or hallucinations are present during an episode of depression, the diagnosis is referred to as Major Depression, with Psychosis. Almost one-third of young, prepubertal clinically referred children with depression experiences either hallucinations or delusions related to their depression. For example, they may hear voices telling them that they are worthless, commanding them to kill themselves, they may be convinced that the world is coming to an end, or that they have an incurable medical illness. These symptoms are usually associated with more severe depression and diminish as the depression remits. Adolescents with depression and psychosis **have a higher risk of** eventually going on to have an episode of Mania, Hypomania or Mixed State, therefore changing the classification of their illness to Bipolar Disorder.

**Dysthymic Disorder**

This condition is characterized by **chronic**, long-standing depressed/irritable mood or loss of interest in usual pleasures and activities, along with other symptoms of Major Depression, but without the severity of a Major Depressive Disorder. For adults, the condition must have been present for **two years** to be considered a Dysthymic Disorder. For children and adolescents, the condition must have been present for one year. The condition persists yet at times the symptoms may be "on and off" with normal moods returning for short periods of a few days to a few weeks. The diagnosis should not be made if the return of normal mood lasts for more than a few months. Psychotic symptoms are not present. Dysthymic Disorder can be described as mild to moderate depression that is both chronic and intermittent. (If depression is a "gray sky about to rain," dysthymia is "partly cloudy.")

Dysthymia is a serious condition due to its chronicity and may often lead to significant long-term impairment for the individual. Children may experience social and academic delays due to the Dysthymic condition. Individuals with Dysthymic Disorder symptoms are at higher risk of developing multiple depressive episodes and their depressive episodes tend to last much longer. **Those with "double depression" (experiencing both Major Depressive Disorder and Dysthymic Disorder) may be at high risk for developing Bipolar Disorder.**
Seasonal Affective Disorder

Seasonal affective disorders are characterized by affective episodes (depression, hypomania, or mania) recurring regularly during certain seasons. One form of the condition that has received most of the clinical and research attention is the condition in which fall-winter depression alternate with nondepressed periods in the spring and summer. Seasonal affective disorder is thought to be related to decreased sunlight during the winter months. Individuals affected with this condition who are living in the Northern hemisphere, experience an onset of the depressive symptoms between the beginning of October and the end of November and regular remission of symptoms from mid-February to mid-April. Depression symptoms are frequently mild to moderate but may be severe. Commonly reported symptoms are decreased activity, increased eating, carbohydrate craving, weight gain, oversleeping, sadness, irritability, anxiety and decreased sex drive. Social withdrawal and impaired work functioning are also common symptoms. It is important to diagnose this particular type of depression because a specific form of treatment called "light therapy" may be helpful.

Attention Deficit/Hyperactivity Disorder

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), Attention Deficit/Hyperactivity Disorder and a Manic Episode are both conditions that are characterized by excessive activity, impulsive behaviors and poor judgment. However similar, Attention Deficit/Hyperactivity Disorder is a clearly different and separate condition from Mania. Attention Deficit/Hyperactivity Disorder can usually be distinguished by its chronic rather than episodic course; absence of clear onsets and offsets; early onset (usually before age 7), and the absence of abnormally elevated moods or psychosis. However, there is recent evidence indicating that the course of Bipolar Disorder for children may not be episodic but more of an ongoing state. Mania is distinguished from ADHD by symptoms such elation, increased energy and hypersexuality. It is also important to note, a child/adolescent may have both Attention Deficit/Hyperactivity Disorder and Bipolar Disorder. In fact very early onset Bipolar Disorder is often comorbid with Conduct Disorder and ADHD.

Substance-Related Disorders (alcohol or drug abuse)

For some individuals the abuse of a substance (alcohol, drugs, medications, or toxins) may bring on symptoms like those seen in a Manic episode. It is essential to distinguish which problem occurred first, the mood disorder or the substance abuse. If Manic-like symptoms occur only in the context of intoxication with a drug (e.g., cocaine or amphetamine), it would be referred to as a substance-induced mood disorder and the treatment would be modified.

Substance abuse often is a complication of Bipolar Disorder and effective treatment of the Bipolar Disorder may actually decrease the substance abuse.
Borderline Personality Disorder

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), a Personality Disorder is an enduring pattern of thinking, feeling, and behaving that deviates from the general expectations of the individual's culture and leads to distress or impairment. The features of a Personality Disorder usually become recognizable during adolescence or early adulthood. There are several types of Personality Disorders. We will highlight Borderline Personality Disorder, as there are a few similar features to Bipolar Disorder.

The essential feature of **Borderline Personality Disorder** is a long lasting pattern of unstable and intense relationships, unstable self-image, and noticeable impulsivity. Impulsive behaviors are often potentially self-damaging such as spending money irresponsibly, driving recklessly, binge eating or abusing drugs or alcohol. Individuals with Borderline Personality Disorder exhibit recurrent suicidal behavior and acts of self-mutilation. They may experience chronic sense of "emptiness." become easily bored and may experience difficulty controlling anger.

Borderline Personality Disorder often co-occurs with mood disorders like Major Depression and Bipolar Disorder and may be a consequence of the psychosocial "scarring" of repeated episodes of mood disorder.

Oppositional Defiant Disorder and Conduct Disorder

**Oppositional Defiant Disorder** is a condition in which the child/adolescent exhibits a recurrent pattern of negative, disobedient, defiant, and hostile behavior toward authority figures. Additionally, parenting efforts may be extremely difficult, due to the chronic disobedience displayed. **Conduct Disorder** is a similar condition to Oppositional Defiant Disorder, however involves more serious behavior violations in which the child/adolescent is getting in trouble at school and even with the police. They may break laws, steal, set fires, and destroy property. Children/adolescents with Conduct Disorder exhibit severe behavior difficulties that involve violating the basic rights of others and or serious violations of major societal rules. When either of these two conditions co-exist with other psychiatric conditions the diagnosis, course of illness and treatment is often complicated.

**Anxiety Disorders (Generalized Anxiety; Separation Anxiety; Panic Disorder; Social Phobia)**

Anxiety disorders are among the most common childhood psychiatric illnesses. Children and adolescents who are afflicted with anxiety often experience considerable distress and impairment in their day to day functioning. They may avoid situations that are important for their development such as school, peer involvement and functioning independently from parents. An anxiety disorder may make you feel nervous most of the time, without any apparent reason. The anxious feelings may be so uncomfortable that to avoid them, the individual may stop some everyday activities. There are several types of anxiety disorders. However, the two
most common for children are Generalized Anxiety and Separation Anxiety. Generalized Anxiety Disorder (GAD) is much more than the normal anxiety people experience day to day. The essential feature is excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities. Separation Anxiety is defined as a disorder with developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached. Children with separation anxiety disorders may refuse to go to school and may complain of physical symptoms. Panic Disorder is another type of Anxiety Disorder that does occur in children and adolescents. Individuals with Panic Disorder have feelings of terror or panic that strikes suddenly and repeatedly without warning. The individual experiences extreme anxiety between episodes and may experience symptoms such as heart palpitations, excessive sweating, shortness of breath, trembling, nausea, feeling dizzy, choking sensation, or fear of losing control or fear of dying. The essential feature of Social Phobia is an intense and persistent fear of social or performance situations in which embarrassment may occur. Individuals with Social Phobia fear that others will see them as anxious, weak, “crazy” or stupid. The person typically will avoid the feared situations. The fear or avoidance of the social situation must interfere with the person’s normal functioning or cause significant distress to be considered a Social Phobia.

Anxiety Disorders frequently co-exist with other psychiatric disorders (especially with depression).

**COURSE OF ILLNESS**

**Episodic**

As we have discussed, Bipolar Disorder is a recurrent disorder. Approximately 90% of adults who have a single Manic Episode go on to have additional episodes. However, the first presentation of Bipolar Disorder is usually a depressive episode. A very few people have only manic episodes and most people will alternate between manic and depressive episodes. Frequently, an episode of one type is followed immediately by an episode of the other type. Nearly 60-70% of Manic Episodes occurs immediately before or after a Major Depression Episode.

Individuals with Bipolar Disorder tend to have a higher number of episodes during their lives than individuals with Unipolar Major Depression Disorder.

Between 15% and 30% of adolescents with Unipolar Major Depressive Disorder may have additional episodes that will involve manic or hypomanic symptoms at which point they would be reclassified as having a Bipolar Disorder. This
reclassification occurs less frequently as people become older and has an increased number of depressive episodes. Conversely, a much higher proportion of patients who have their onset of depression prior to adulthood eventually develops a Bipolar Disorder. Research indicates that up to 50% of children and adolescents with Major Depressive Disorder with psychotic features will have additional episodes that will involve manic or hypomanic symptoms. New episodes (recurrence) of depression are very high (up to 80%) among people who have already had three episodes, who have an early age of onset, double depression (Dysthymia and Major Depression), Bipolar Disorder, and the co-existence of other psychiatric problems (such as Attention Deficit/Hyperactivity Disorder and or substance abuse), in addition to the depression. Substance abuse is closely associated with mood disorders in adolescents. Manic, hypomanic and "mixed states" can be precipitated by drug or alcohol abuse. During "mixed states" the individual is particularly at risk for suicidal behaviors.

**Suicidality**

Suicide is the most serious outcome of mood disorders, such as Bipolar Disorder and Unipolar Major Depression. Research studies for adults diagnosed with Bipolar Disorder, indicate that most suicides occur during the depressive episode or mixed episode, not the manic episode. Feelings of worthlessness and hopelessness may overcome the depressed person, which may lead to suicidal thoughts and at other times, suicidal acts.

Completed suicide occurs in 10%- 15% of individuals with Bipolar I Disorder. While all suicides are not committed by those who are clinically depressed, and most clinically depressed people do not attempt or commit suicide, there is a strong connection between Bipolar Disorder, Major Depression and suicide. Recent studies show that adolescents with Major Depression or Bipolar Disorder are 30 times more likely than community controls to complete suicide. Studies have also indicated that for individuals diagnosed with Bipolar Disorder, "mixed state" may be the most dangerous clinical phase of the illness for completed suicide. Additionally, the individual is at high risk for suicide while "switching" from the manic/hypomanic state to the depressive state.

Suicidal patients with mood disorders such as Bipolar Disorder or Major Depression may need to be psychiatrically hospitalized for their own protection. However, for those who are hospitalized for suicidality, the greatest risk period is during or immediately following the psychiatric hospitalization. Suicide may occur very early in a depressive episode, or after a chronic course. For this reason, it is important to insure continuity of care for your child if he/she is being discharged from an inpatient psychiatric unit.
Risk Factors for Adolescent Suicide:

- Major Depression or Bipolar Disorder
- Hopelessness
- Drug and alcohol abuse
- Availability of firearms
- High suicidal intent
- Previous suicide attempt
- Lack of treatment
- Co-existing condition such as anxiety
- Talking about death or suicide; saying “good-byes,” giving away possessions, making wills
- Engaging in self-destructive behavior
- Behavior problems
- Physical or sexual abuse
- In the midst of a legal or disciplinary crisis
- Family history of suicidal behavior

Suicide is the third leading cause of death for persons between the ages 15-24, ranking behind only unintentional injuries and homicide. In the last 25 years, the suicide rate of adolescents and young adults between the ages of 10-14 and 15-24 has increased three-fold. There is substantial evidence that the increase in the suicide rate among young people may be associated with an increase in the prevalence of alcohol abuse and availability of firearms. It is also suggested that an association exists between alcohol intoxication and suicide by firearms. Some people believe mood disorders are becoming more common and beginning earlier in life, and that this so-called “secular trend” may be contributing to the rise in the youthful suicide rate.

Due to this high correlation between completed suicides and gun availability—it is strongly recommended that all firearms be removed from the home, especially if a family member is experiencing current Major Depression or Bipolar Disorder and or a past episode of depression. Research indicates that it is crucial to remove firearms from the home, even if the firearms are locked and ammunition is unavailable. Availability of firearms (especially a loaded gun) in the home may be
a risk factor for teen suicide even if the teen shows no obvious signs of mental disorder.

CAUSES OF BIPOLAR DISORDER

Currently, there is no known single cause for Bipolar Disorder. Rather, there appears to be a variety of interrelated factors. Among these factors are genetic predisposition, biological imbalances, personality characteristics, learned behavior or thought patterns, and stressful life events.

Genetic/Familial Factors

It has long been known that Bipolar Disorder runs in families. Research has indicated that there is a genetic aspect to Bipolar Disorder and Major Depression. Genetic factors are those inherited traits under biological control (e.g., hair color or eye color). Bipolar Disorder and other psychiatric disorders of childhood have been noted repeatedly in many children of adults who are diagnosed with Bipolar Disorder or Major Depression.

Biochemical Factors

Several years ago physicians noted that certain medications had strong mood-altering effects, leading to the idea that mood disorders could be a function of a biochemical disturbance that could be stabilized by drugs. The results of many clinical studies have revolutionized the treatment of psychiatric disorders.

Research involved in the study of animal and human brain tissue has also added to the evidence that biochemical imbalances exist that contribute to Bipolar Disorder. A group of chemical compounds, the biogenic amines (e.g., serotonin, dopamine) have been shown to regulate mood. These chemical messengers or neurotransmitters transmit electrochemical signals from one nerve cell in the brain to another. These neurotransmitters (messengers) set in motion the complex chemical interactions that control our behaviors, feelings, and thoughts. Studies suggest that too much, too little, or an imbalance of these messengers may be why a person experiences mania and depression. Serotonin and norepinephrine are two of these neurotransmitters thought to be related to depression. Serotonin is believed to be associated with energy level, sleep, and aggression. In fact, genetic and biological factors may interact, since non-depressed youth whose parents have depression show very similar biological changes in serotonin, to those who are actually depressed.
Cognitive Distortions and Social Skills

Cognitive theories of depression maintain that distorted thinking is central to clinical depression. Cognitive distortions may occur as a consequence of being depressed or manic, or it may exist prior to the depressive or manic episode. It is unclear as to which came first, cognitive distortions or mood disturbance. Currently, there is evidence that cognitive distortions can be both a contributor ("cause") to the developing the disorder or a result ("effect") of the disorder.

This type of thinking can be described briefly as a view of the world as cruel, the self as deficient and unworthy, and the future as hopeless. Cognitive distortions include logical errors, dichotomous (black and white) misinterpretation of events, and overgeneralization. The cognitive model suggests that this type of negative thinking is developed early in life and can lead to depression. When under stress, a person with a tendency to negative thinking is more likely to become depressed. For example, if a vulnerable person fails a test, he/she may respond by thinking, "I'm a failure." If a boy/girl is rejected by a girl/boyfriend, he/she may think, "without him/her, I'm nothing." This type of thinking may lead to worsening self-esteem and increasing depression. There is evidence that parental and child cognitive styles are related, which could be due to either modeling or genetics.

Environmental and Other Factors (Loss, Stress, Life Events, Chronic Illness)

Researchers have found that certain kinds of life events including a serious loss, death of a loved one, increased conflicts at home or school, a breakup/divorce, failing school/the loss of a job or the move to a new home can trigger depressive episodes, especially in those that are vulnerable. Chronic illness may also be a precipitant to the onset of episodes of depression. A number of studies have shown more "exit" events (divorce or loss), more undesirable events, more "severely threatening" events, and more uncontrollable events in the six months prior to the onset of depressive episodes.

Circadian Rhythm Disturbance

Sleep disturbances are key symptoms of both episodes of depression and mania. Insomnia (difficulty sleeping) or hypersomnia (sleeping too much) frequently occur within a depressive episode of Bipolar Disorder or Unipolar Major Depression. Patients in a manic episode, sleep very little, if at all. There is some evidence to suggest that sleep disturbances are not only symptoms of the illness, but may be related to the actual development of the disorder, in fact, sleep deprivation may trigger an episode of mania or hypomania episodes. Therefore, maintaining regular sleep patterns "in between" episodes is an important "preventive" strategy.
Seasonal Patterns

There is evidence suggesting a possible link of seasonal variation and the occurrence of episodes of mood disorders. Certain patterns indicate two broad peaks of Major Depression, one in the spring and a smaller peak in fall. The pattern is similar for suicide, a large peak in the late spring and a smaller peak in October. The research is limited, however episodes of Mania appear to peak in the spring months.

COURSE OF TREATMENT

The specific course of treatment varies based on the severity of symptoms, type of episode (depression or mania), chronicity of illness, and co-existing conditions. The course of treatment for Bipolar Disorder is ongoing due to the chronic nature of the disorder. Generally, treatment can be considered to occur in three overlapping phases:

The first phase (acute phase) is active treatment directed at symptom improvement and stabilization. This phase includes the assessment of suicidal risk and other symptomatology and providing psychoeducation to the patient and family about the disorder and treatment of choice. Prior to beginning treatment, the therapist should also conduct a careful review of associated problems such as social, academic and family functioning. Building rapport and a solid therapeutic relationship as well as providing support to the patient and family is an important ongoing component of therapy.

The acute outpatient treatment of Bipolar adolescents may consist of once to twice weekly medication management sessions and therapy. The interventions are structured and often involve teaching the patient how to monitor moods (mood charting) and cope with interpersonal difficulties. Once improvement has been established, the frequency of sessions usually begins to taper off to weekly and possibly to every other week. Careful attention is paid to the clinical condition of the child/adolescent as to whether diminishing frequency is appropriate.

The second phase (continuation phase) is a continuation of active treatment directed at avoiding relapse (return of symptoms). The frequency of sessions may be less frequent, however interventions continue to be structured similarly as within the acute phase of treatment. Symptoms should continue to be monitored.

The third phase of treatment (maintenance phase) involves continued interventions to prevent recurrence (the appearance of new episodes). This phase of treatment involves continuing to monitor symptoms, evaluating progress, revising treatment goals, and developing a plan for maintenance. Parents and patients are encouraged to monitor for recurrence and to come back to more frequent treatment
at first notice of even the mildest symptom. The return of mild symptoms could be a signal of recurrence and can be more efficiently treated at the early stage.

For individuals with Bipolar Disorder or multiple episodes of Unipolar Major Depression, chronic maintenance treatment is recommended. The course of treatment may also be prolonged for individuals experiencing “double depression” (Major Depression and Dysthymia).

**TYPES OF TREATMENT**

**Medications are a must for treating the individual diagnosed with Bipolar Disorder, in particular when the disorder is affecting the child’s functioning.** Medications are essential for treating the acute symptoms, to prevent relapse (that the same episode will reappear), as well as to prevent new episodes. Effective treatments are available now, despite the enormous amount that still remains to be learned about the causes and treatments of Bipolar Disorder.

Many families become concerned that their child will become addicted to these medications. Mood stabilizers and anti-depressant medications are not addictive.

**Medications**

There are specific drugs widely used to treat Bipolar Disorder: Mood Stabilizers such as Lithium Carbonate, Valproate (Depakote) and Carbamazepine (Tegretol). Antidepressants like the Selective Serotonin Reuptake Inhibitors (SSRI’s); and Antipsychotics such as Resperidone.

**Mood Stabilizers**

Three mood stabilizing agents have been widely used for the treatment of Bipolar Disorder - Lithium, Valproate (Depakote) and Carbamazepine (Tegretol).

Additionally, Gabapentin (Neurontin), Lamotrigin (Lamictal) and Topiramate (Topamax), medications that are usually used to treat seizures, appear to be useful for the treatment of Bipolar Disorder, but more studies are necessary.

These medications are the main treatment for Bipolar Disorder including, the acute treatment of manic symptoms; once stabilized, as a way to
prevent relapse as well as future episodes of mania and depression and to augment treatment of refractory (unresponsive) depression. Some symptoms may improve after 1 or 2 weeks of taking these medications. However, usually it can take 4-6 weeks to notice significant improvement.

Lithium Carbonate

Lithium Carbonate was the first of the mood stabilizers to achieve wide use. Lithium is a naturally occurring element that contains many properties in common with the electrolytes present in body tissue and fluids. Use of Lithium has been shown to be quite helpful in treating episodes of acute Mania and preventing subsequent episodes of Mania and Depression, but Lithium is less effective in the treatment of acute depressive episodes. Lithium is taken several times daily to achieve a certain blood level that is effective in preventing wide mood swings. A balance must be struck between effective "prevention" and "flattening" out the bipolar patients' "personality" and flair, which may lead to non-adherence to medication.

For adolescents with mania, Lithium may be ineffective, particularly in those with prepubertal onset, co-existing behavior disorders, and mixed state/rapid cycling. For those conditions, Valproate or Carbamazepine may be superior, however further studies are necessary. In adults, the co-occurrence of depression and mania has been reported to respond better to Valproate than to Lithium.

Side effects may include nausea, stomach cramps, thirstiness, increased urination, loose stools, diarrhea, and exacerbation of acne, hand tremors, weight gain, and feelings of being slightly tired. These effects may be brief, but some may persist for the entire treatment. Sometimes Lithium can decrease the functioning of the thyroid gland. When this gland does not function well it can produce tiredness, increase in weight, slow thinking and movement. That may be compounded with the symptoms of depression. Although, comprehensive, Lithium may cause kidney problems. Thus, before taking Lithium a patient needs to have laboratory tests for kidney functioning. If a person is urinating too much the physician needs to be notified. Regular blood tests are always given during Lithium treatment to ensure that the level of the drug is within the therapeutic range (usually between 0.6 and 1.1 mEq/l). High levels of Lithium in the blood may be dangerous. When Lithium levels are too high, symptoms such as slurred speech, confusion, unable to walk well, vomiting, diarrhea, and/or severe tremors serve as a warning to the patient and relatives to be seen immediately by their physician or the local emergency room. These
symptoms can make the person appear as if they were "drunk." Individuals taking Lithium should not be on sodium (salt) restricted diets. Also, if the patient is not going to have enough liquids, or has an illness that produces diarrhea or vomiting he/she should contact their physician. If you or your child/teen are on Lithium and become or suspect you may be pregnant, please notify your physician immediately. Exposure to Lithium in utero has been associated with heart defects in babies.

Valproate (Depakote)

Valproate is a medication that has been used to treat epilepsy but is quickly becoming a first-line drug for the treatment of Bipolar Disorder. As noted, Valproate may be especially helpful for bipolar youth with rapid cycling or mixed state.

Among the possible side effects of Valproate (Depakote) are nausea, vomiting, drowsiness, weight gain, hand tremor, sometimes hair loss and possible changes in the blood cells. In women of reproductive age, ovarian cysts (especially in those who have gained too much weight) are reported. A rare but serious complication is liver damage; therefore the people taking this medication, in particular, young children need careful monitoring including blood tests to monitor possible liver problems. These side effects do not occur for most individuals but if they do occur, the psychiatrist should be notified immediately. Routine blood tests to monitor the blood levels of Valproate are necessary. Blood levels should be between 50 and 120 ug/mL. If you or your child/teen are on Valproate and become or suspect you may be pregnant, please notify your physician immediately. Valproate has been associated with birth defects especially if used during the first three months of pregnancy.

Carbamazepine

Medications such as Carbamazepine (Tegretol) are used to treat epilepsy, also have been used successfully for the acute treatment and prevention of Bipolar Disorder. The possible side effects of Carbamazepine are occasional dizziness, drowsiness, double vision, skin rashes, nausea and difficulty in coordination. With this medication there is the possibility of a reduction in white and red blood cells and platelets, therefore requiring occasional blood tests. If there are signs of infection, the psychiatrist should be consulted.

In research studies, Carbamazepine has been shown to be helpful for adolescents with Bipolar with Mixed States. Routine blood tests are necessary to check for Carbamazepine blood levels and possible changes in the blood cells. Blood levels are usually
between 8 and 12 ug/mL. If you or your child/teen are on Carbamazepine and become or suspect you may be pregnant please notify your physician immediately as there may be some problems with continuing on the medication.

Antidepressants

Selective Serotonin Reuptake Inhibitors (SSRI’s)

Antidepressant medications like Selective Serotonin Reuptake Inhibitors (SSRI’s) are used to treat the depressive episodes of Bipolar Disorder, once an optimal dosage of a mood stabilizer has been established.

Examples of these medications are Fluoxetine (Prozac), Fluvoxamine (Luvox), Sertraline (Zoloft), Paroxetine (Paxil) and Citalopram (Celexa). These medications work by increasing the brain’s supply of the neurotransmitter called serotonin. These medications are very selective towards the serotonin. This selectivity may explain why these medications tend to cause fewer of the disturbing side effects, such as drowsiness and dry mouth, seen with some other antidepressants. The most common side effects include nausea, stomachache, diarrhea, nervousness, suppressed sexual desire and enjoyment, insomnia/hypersomnia, lack of appetite, weight loss, and after chronic use, perhaps increased weight.

Some depressive symptoms may improve after 1 or 2 weeks of taking these medications. However, usually it can take 4 to 6 weeks to notice significant improvement. Occasionally these medications (as all antidepressant medications) may trigger the symptoms of mania, mixed states and rapid cycling. In this case, the medication must be reduced or discontinued, or if continued treatment of the depression is necessary, increased dosages of mood stabilizers/antipsychotics will be required.

There have been several news media reports about Fluoxetine (Prozac). Many of the positive and negative reports have been distorted and sensationalized.

Other Antidepressants

Other Antidepressant medications such as Bupropion (Wellbutrin), Nefazadone (Seradone), Venefaxine (Effexor) and Monamine Oxidase Inhibitors (MAO’s i.e., Nardil, Parame) can be used to treat the depressive episodes of Bipolar Disorder. One report indicates a lower risk of Bipolar “switch” (to mania) in
bipolar depression treatment with Bupropion (Wellbutrin) than tricyclics or SSRIs but further studies are necessary.

The tricyclics (Imipramine & Nortriptyline) have not been shown to be more efficacious than placebo (a "sugar" pill) in child and adolescent depression and can be fatal if taken in overdose. Therefore, these medications are not used as first choice drugs. In adults, MAOI's are more efficacious than tricyclics for bipolar depression, but this has not been studied in children and adolescents. The greatest problem with using certain types of MAOI's is the diet and drug restrictions a person must follow while using the MAOI's. Only people who are willing to follow the strict restrictions can use MAOI's. Foods that are prohibited include processed meats, certain cheeses, pickles and pickled foods, red wines and sherry, certain drugs such as amphetamines, barbiturates, some cough medicines, nasal decongestants, and certain other antidepressants. Please consult your physician prior to beginning any additional medications. The interaction of MAOI's with any of these substances can cause quick and severe rise in blood pressure, accompanied by severe headaches and other symptoms.

**Overall, the antidepressants appear safe for use during pregnancy however if you become or suspect you may be pregnant, please consult with your physician.**

**Antipsychotics**

**Neuroleptic**

Neuroleptic medications are useful for treating psychotic symptoms such as delusions and or hallucinations as well as at the beginning of treatment to help control psychomotor agitation (extreme physical uneasiness) and to restore normal sleep. When used to control agitation, the antipsychotic medication can be tapered down, once the Lithium or other medication has shown effect.

Some of the "old" neuroleptic medications such as haloperidol (Haldol) and chlorpromazine (Thorazine) had many potentially negative side effects, namely sedation, cognitive slowing, extrapyramidal symptoms and over along time of use they can produce a movement disorder called tardive dyskinesia. The "new" (often referred to as "atypical") antipsychotic medications such as risperidone (Risperdal) and olanzapine (Zyprexa) have been shown in adults to be very effective, safe medications with fewer side effects. The biggest problems with "atypical" antipsychotics are weight gain and sedation. Despite the obvious reasons for desiring less side effects, studies in children/adolescents are necessary.
The Combination of Medications

As we have discussed, Bipolar Disorder involves the cyclic alternating from one extreme episode to another. Subsequently, it is common to use a combination of medications in the treatment of Bipolar Disorder. Often, one medication may be needed to control/prevent the symptoms of mania and additional medication for the treatment of the depressive symptoms.

Finally, children and adolescents with Bipolar Disorder may have other psychiatric disorders such as Attention Deficit Disorder which require treatment with other types of medication.

Specifically, the treatment of Bipolar Disorder involves the use of a mood stabilizer and a SSRI medication. If the patient also experiences significant agitation and or delusions/ hallucinations, an antipsychotic medication may be added temporarily.

Psychotherapy

Psychotherapy involves the presence of an interested, but objective person (therapist) and the use of talking to define and resolve problems. There are many types of psychotherapy but only a few are designed to specifically treat mood disorders. These are usually short-term therapies with a typical duration of six months or less. All psychotherapies aim at improving the person's social and personal functioning. Some therapies are designed to help the individual alter ways of thinking and viewing, while other therapies deal more with changing behavior and interaction patterns with others.

Psychotherapy is useful for the individual with Bipolar Disorder, especially when experiencing an episode of depression or while stabilized. However, when the person is so troubled they can't talk, or for the person with severe psychotic or acute manic symptoms, medication treatment is inevitable and must begin prior to psychotherapy.

Psychotherapy is often used in combination with medication therapy (pharmacotherapy). The most commonly used psychotherapies for mood disorders include cognitive, supportive, family, behavioral, interpersonal and psychodynamic psychotherapy.

Cognitive Therapy

This treatment focuses on the individual's negative or distorted thinking patterns. It is often a characteristic of the individual in a depressive episode to minimize good events and overemphasize bad ones. For example, a person may do well on a test, but attribute it to "luck" or may fail one out of seven exams and focus unduly on the one failure.

During depressive episodes, the individual may over-generalize or think that a single event will happen over and over again. For example, consider the boy
who asked a girl for a date and was turned down. An example of overgeneralization would be to conclude, "I'm never going to get a date; girls are always going to turn me down." Another cognitive distortion is that of "all or nothing," black/white categories. "All or nothing" thinking is clearly illogical because things are not usually completely one way or the other. This type of thinking causes people to fear any mistake or imperfection because they will then see themselves as a complete zero and feel inferior, worthless, and depressed.

During manic/hypomanic episodes (unless very severely impaired or agitated), cognitive therapy may also be helpful. Initial goals of cognitive therapy may be related to symptom monitoring as well as providing psychoeducation about Bipolar Disorder, to the patient and family. Therapy can focus on assisting the individual to develop enhanced coping skills, problem solving strategies, emotion regulation skills as well as assisting the individual to monitor, evaluate and modify their thoughts. The therapist helps the person develop skills to continue self-correction and evaluation that can be used long after the acute therapy has ended.

Extensive evidence now exists in depressed adults and adolescents that this is an efficacious treatment for depression (Unipolar Depression). Further research is indicated to determine the efficacy of CBT with Bipolar patients.

**Supportive Therapy**

In this approach, the focus is upon developing a helpful working relationship with a therapist who can assist people to clearly review and then better understand the problems that they may have experienced. The therapist and the person, then work closely together by forming a relationship based on trust, mutual respect, and genuine concern, in which they review the person's problems and coping abilities. The therapist tries to help the person to decide on more constructive ways of dealing with stressful circumstances. Time is devoted to allowing persons to discuss their feelings and beliefs about different experiences. This therapy assumes that by developing a special relationship with the therapist and by allowing the person to determine what takes place during the session, a person will be more optimistic about a specific problem and will show improvements in handling similar problems. Supportive treatment is an important element of all treatment, including pharmacotherapy, but probably is not sufficient as a sole mode of therapy for mood disorders.

**Family Therapy**

Family therapy actively involves other family members in the treatment of the child/adolescent. This form of treatment strengthens communication skills between parents and children and teaches problem solving strategies that can be helpful in reducing stress and frustration secondary to dealing with the child's mania/depression. Families learn how to recognize symptoms of depression
and mania; how to identify sources of stress or conflict; how to improve strategies to negotiate their differences and ultimately identify preventative strategies. Enhancing parent-management strategies may assist the family to manage the child's problematic behavior. It is believed that by helping the parents and children to be more aware of each other's ideas and feelings, mutual support will increase and this will help reduce the child/adolescent's tendency toward isolation and negative interactions. Reduction in family stress has been shown to decrease the likelihood of relapse in adults with Bipolar Disorder. In this way the treatment can enhance the recovery process.

**Behavioral Therapy**

This therapy assumes that depressive behaviors are learned and reinforced in the environment. An example would be the shy, awkward girl who doesn't get asked to dance at a party. She may drop her head and her shoulders may hunch, and her own behavior may discourage any other people from asking her to dance. Given enough of this negative reinforcement, the pattern becomes fixed. Behavior therapy focuses on changing the person's behaviors and their environment. The person can be taught to monitor their events, decreasing the unpleasant ones and increasing the pleasant ones. Changing the person's environment by encouraging close associates to pay attention to the depressed person's positive behaviors would be another intervention of some behavioral therapies. Specific social skills are taught and self-reward after positive behavior is encouraged. Behavioral techniques are an important component of cognitive therapy, particularly in those who are more severely depressed.

**Interpersonal Therapy**

This particular therapy focuses on disturbances in functioning between the individual and others in his/her life. Difficulties are assumed to arise as a result of grief, normal life changes, role transitions, and problematic or unfulfilled personal relationships. This approach deals with the current life situation of the patient and tries to resolve current problems. The therapist will teach the person about mania and depression how their feelings connect with important events within their environment. They may also focus on changing behavior and social skills. This form of treatment has been shown to be efficacious in adults and has shown promise in adolescent depression as well.

**Psychodynamic Therapy**

This approach involves seeing depression as a symptom of a complex set of character problems stemming from the person's early childhood experiences. Psychodynamic therapies aim to treat the "whole person" instead of the "symptoms" such as depressed mood. Psychodynamic therapies focus on the unconscious conflicts, which are thought to be central to the depressed state of the person. A key element in psychodynamic treatment is "transference," a
situation where the individual in treatment “transfers” perceptions and feelings about important childhood figures onto the therapist at therapy sessions. The therapist helps the patient change relationship patterns that are carried from the past. Currently, there is no empirical evidence to support the use of psychodynamic psychotherapies in treating adolescent mood disorders.

Combination of Medication and Psychotherapy

Medication is the primary treatment for Bipolar Disorder. However, the problems and impairment that occur for the individual with Bipolar Disorder are clearly applicable for therapeutic involvement. Therapeutic sessions may involve dealing with concerns related to taking prescribed medication, understanding, coping and managing with the illness as well as dealing with issues related to problem solving and relationship difficulties. The illness can be costly to the individual and family. The provision of verbal and written psychoeducational material to the entire family is an important intervention.

In summary, there are beneficial outcomes usually achieved by simultaneously reducing symptoms with the medication and promoting learning and coping through psychotherapy, which has been empirically shown for adult, but not for child-onset Bipolar Disorder.

Other Treatments

Light Therapy

Light therapy consists of sitting for 30-40 minutes, usually once a day early in the morning, in front of a special lamp which provides a measured amount of full spectrum or specific wavelength light equivalent to standing outdoors on a clear spring morning. The light, unlike regular light, replicates the natural daylight without the dangerous ultraviolet.

Light therapy has been successfully utilized in the treatment of Bipolar patients, especially those who have the onset of depressive episodes in the late fall or winter. In some individuals with Bipolar Disorder, excessive light has been noted to be associated with the onset of Hypomania.

Electroconvulsive Therapy (ECT)

The use of ECT in children and adolescents has long been the subject of scrutiny and controversy. Despite the controversy, it has been found that in normal clinical practice ECT is often effective for treatment-resistant cases and in severe, incapacitating conditions. Although ECT is an effective treatment for some severe psychiatric conditions and has few side effects, it is seldom used for children and adolescents. Indications, responses, and unwanted effects are
similar to those observed in adults (Walter & Rey), and for rare refractory case, it can be life saving.

LEVELS OF PSYCHIATRIC CARE

In general, the principles governing the treatment of Bipolar Disorder in children and adolescents are similar to those of adults. Research has also indicated that the very early onset of Bipolar Disorder is more likely to involve comorbid (co-existing) non-affective conditions, "mixed states," and "rapid cycling." As previously stated, these conditions often require more intensive treatments.

The choice of clinical treatment for Bipolar Disorder is based primarily on the type of current episode, as well as the nature and severity of symptoms, and current level of impairment. Most often, for individuals clearly diagnosed with Bipolar Disorder, the first line of treatment is medication. The level of psychiatric care will be determined by factors such as the individual's ability to maintain safety/refrain from suicidality/homicidality, the current level of impairment, as well as the availability of supervision/monitoring by family.

Emergency Care/Inpatient Hospitalization

As we have stated, the presence of suicidal and/or homicidal thoughts and behaviors are symptoms of Bipolar Disorder and Major Depression. When there are concerns related to the safety of a child or adolescent due to acute suicidality/homicidality, the immediate intervention is emergency care to assess the need for a psychiatric hospitalization. Psychotic mania and or states of extreme physical agitation usually require hospitalization.

Partial Hospitalization

Immediately following the discharge from a psychiatric hospitalization is a very risky and difficult transition for children and adolescents. "Partial" hospitalization programs help ease the transition from inpatient hospitalization back to the child/teens "real world." In general, "partial" hospitalization programs are a "step down" from being hospitalized for 24 hours per day, to one in which the child/adolescent attends 4-8 hours per day. They may be used to avoid hospitalization.

The individual may participate in group, individual and family therapies, as well as receiving daily medication management. The treatment focuses on helping the individual achieve and maintain stability as well as to facilitate continuity of care/transition from "partial hospitalization" to the less structured setting of outpatient treatment.
Outpatient Treatment

Psychiatric outpatient treatment is less frequent and intensive than psychiatric hospitalization or partial hospitalization. Typically, outpatient treatment consists of phases of treatment (acute, continuation and maintenance - see "Course of Treatment", page 29) in which the individual attends therapy and medication management. Often, the individual has a treatment team that consists of a clinician, nurse, and psychiatrist, who provide the treatment. The particular model of treatment offered varies from site to site, but generally include medication management, individual, family, or group therapies. Frequencies of visits vary depending on the clinical need of each individual.

FROM THE PATIENT'S PERSPECTIVE

Teenagers with Bipolar illness describe the "switching" from one "state" to another as a feeling of being "completely out of control." For the individual diagnosed with Bipolar Disorder (and their families), the idea of experiencing future similar episodes is difficult to accept. A young person experiencing the first episode of mania may think they are "going crazy." The onset of psychotic symptoms creates total confusion and distress. What used to be a simple and pleasurable outing like going to dinner with your family to a restaurant, becomes a major threat for the individual hearing internal "voices" (hallucinations).

Adolescents who have Bipolar Disorder report their friends and classmates often alienate them. Some people react with concern, anger, withdrawal, rejection, or denial of the illness.

Some adolescents with mild symptoms of mania describe the hypomanic state as one they initially enjoy. The elevated mood and increased confidence is welcomed over the awkward shyness they may normally experience. However the down hill slide to depression their "roller coaster" will soon take, is not something any teen looks forward.

For many who, have experienced previous episodes of mania, hypomania or mixed states, the worry and fear about what will happen in the next episode is a major preoccupation. Feelings of shame and embarrassment may occur, related to previous inappropriate behavior during the manic episode. The question always looms, "when will it happen again."
BIPOLAR ILLNESS AND THE IMPACT ON THE FAMILY

We have learned from many families whom we have worked with that it can be difficult to live with a family member who is experiencing Bipolar Disorder.

Bipolar Disorder affects the whole family

The family may be affected in many ways such as the day to day changes in routines the family may experience due to the family members' impaired functioning. What seemed like such simple tasks in the past, like waking up for school, can suddenly create major difficulty in the home. The family may experience increased anger, frustration, and irritability; subsequently conflict may be increased. Family members may have feelings of guilt and blame, as well as feelings of resentment and shame towards the family member and his or her impact on the family. Family members often may experience anxiety and fear about the illness, wondering when it will go away, or who else in the family will become ill. Families describe feeling the need to "walk on eggshells," especially as their child/adolescent begins to improve. As parents see their child/adolescent begin to improve, they often struggle with questions related to limit setting and discipline. Parents often report not wanting to "rock the boat" by upsetting their child/adolescent. However, it is important to remember that all children/adolescents require consistent structure and limits.

HOW THE FAMILY CAN HELP

Seeking treatment for parents and siblings

As we have described, mood disorders, such as Bipolar Disorder and Unipolar Major Depression do tend to run in families. Thus, one or both parents and or other family members may have a mood disorder that could complicate the situation. It is essential for family members to recognize mood disorder symptoms in themselves, as they will have less ability to handle their ill child if they themselves are not feeling at their best. In a recent study of depressed adolescents, it was found that a high percent of the depressed teens also had at least one parent who was actively depressed. The study noted that untreated parental depression and or anxiety were predictors for poor treatment outcome for the depressed teen. If you suspect that you or someone else in your family is experiencing depression, please let us know and we will assist you in seeking an appropriate referral. Your treatment is an important part of your child's treatment and you can help your child get well by getting well.
Learning about the illness

It is important for parents to be provided with education about their child's diagnosis and treatment plan. It is recommended that the family receive specific education about the illness, medications, therapies, as well as the importance of recognizing the early signs and symptoms of hypomania, mania and depression. Often the family members are the first to notice the early symptoms that are necessary for seeking early intervention. It is also essential that the family be educated in advance, about specific plans for handling emergencies involving suicidality.

Family Members - Partners in the Treatment

Family members are partners in their family member's treatment. Encouraging the person to take medication as directed is an essential way of helping. Adherence with medication is crucial, even once the child/adolescent is doing well. Do not stop medication without consulting your physician. The risk of relapse or a new episode is increased. It is also important to encourage the person to use the psychotherapy sessions to work on problems and concerns. Learning to recognize manic and depressive signs, for example, subtle changes in motivation, sleep, concentration, and mood, will help significantly so that the individual may seek treatment before the illness worsens.

Continued Functioning of the Family

It is important for the family members to take care of themselves and try to go on with their own lives. It is important to go places, see friends, and enjoy yourselves even if the individual does not want to. Family members are long-term support resources for the person, therefore, to be helpful; you must be functioning well yourselves. Although it is very difficult, you must try to not allow the illness to control the whole family or completely disrupt your lives. It is also important to keep the family functioning normal. Do not become dominated by the person's needs and demands or allow yourselves to feel guilty for not responding to his/her every need. Obviously, this will be difficult to do if your family member is "in episode." During an "acute" episode when symptoms are most impairing, the child/adolescent may require close supervision and monitoring. Providing a safe environment during the acute episode is necessary as most likely the child/adolescent may experience poor judgment. This symptom can vary in degree of severity. In its most serious form, individuals may engage in extreme, dangerous behaviors or homicidal ideation. Clearly, poor judgment has the potential for lasting consequences. It is imperative to provide a safe environment during this acute phase. At the same time, remembering that the "poor judgment" exhibited by your child/adolescent is not being done "on purpose" and is clearly not behavior s/he would normally experience.
It is critical to use "symptom free" intervals between episodes to take care of yourselves as well as discuss strategies for handling future episodes if they occur. It is crucial that parents of the child or teen take time for themselves. As we are routinely reminded by the flight attendant on an airplane, "If you are traveling with a child and an emergency situation would arise, please place the oxygen mask on yourself first, before placing it on your child." "You will be unable to take proper care of the child unless you are first taken care of."

Communication

Communication between parents and teenagers can break down during times of high stress. Bipolar Disorder, like other illnesses, can be very stressful for everyone in the family and very often lead to more arguments. Although it is not always easy, it is during these times of greater stress that family members need to talk (but not if too stressed) with each other in helpful ways. The following guidelines may be helpful:

First try to talk directly with your child/adolescent about the things that concern you. If possible, address small issues as they come up rather than letting small irritations build to a point of great tension. Teenagers like a parent who can listen but very often react negatively to advice. It can be helpful to ask your child first if they want suggestions before offering alternatives. It is inevitable that you and your child/adolescent will disagree about a variety of issues. Clear, simple rules and reasonable expectations will make it easier for your child to know what to expect. Some parents are afraid to praise their children but praise and positive feedback are very important. Criticism and negative remarks are best delivered in a calm tone of voice. Remember that improvement is a gradual process and parents who notice small positive changes and comment positively on those changes can aid their child/adolescent's recovery greatly.

If your adolescent is diagnosed with Bipolar Disorder and is in a manic or hypomanic state, talking about your concerns may need to be delayed until he/she is stabilized. Immediately focus on assuring that your teen is in a safe environment. Let the treatment team help you. Call us immediately. Know your emergency backup plan.

It is important for family members to say what they feel directly to the depressed person, even when the feeling being experienced is anger. However, it is one thing to tell someone you are angry, and another to shout or lose your temper. Tell the person when you are unable to be supportive to them. It is acceptable to say you can't deal with something at a particular time. Be truthful and direct about negative feelings. You cannot protect the person from your negative feelings. It is especially important that you express your positive feelings about the person. Let them know when you notice improvements in their mood or behavior.
The tone of voice and facial expressions used when communicating is very important. How you say something to the depressed individual is often as important than actually what you say. If you are experiencing frustration and a lot of blowups at home, then having a therapist help improve communication between you and your teen should be a part of the treatment.

Lastly, as a parent you may need a supportive person who will listen to your worries. Sometimes children inappropriately try to serve as a parent's main support but over the long run this can lead to too much stress for the child and ineffective support for the parent. Communicate your needs to other adult family members or friends who can provide the support you deserve.

**Changing Expectations**

It is important to recognize that symptoms of mania and depression may limit your child/teen's performance in such areas as schoolwork and interpersonal relationships. The person is not to blame for his/her situation and neither are you. Accepting that the family member is experiencing a legitimate medical illness is essential to their recovery. Be hopeful about the person's outcome because Bipolar Disorder is very treatable, however, it may be necessary to modify one's expectations of the person, especially during specific episodes. Recognizing that the recovery is gradual and supporting their improvements along the way is especially important. You may work with the therapist to set reasonable expectations for your child/teen.

**COPING WITH BIPOLAR DISORDER**

**Dealing with Emergencies (such as suicidality, physical violence, psychotic episodes and/or states of extreme physical agitation)**

Families can learn to detect slight changes or early symptoms that occur at the beginning of episodes. Recognizing the symptoms early and seeking treatment at that time is essential. Noticing subtle changes in mood, behavior and sleep patterns may be helpful in "spotting" possible evidence of relapse/recurrence.

In terms of suicidality, one of the most important factors for prevention of suicide in children and adolescents rests on the ability to recognize individuals at risk for suicidal behavior. Though a depression or manic episode may appear mild, it does not exclude the possibility of suicide. Remember that it is not true, as many people believe, that a person who talks about suicide will not attempt it. Those who attempt suicide often appeal first for help by threatening to do so.

If your family member begins talking about death, suicide, or homicide, it is crucial that you contact the professionals involved in his or her treatment. If the individual has talked about suicide or homicide, it is essential to ask for specific
information about their immediate safety. Making a "no-suicide/no harm contract", which is a verbal promise that the child/teen will agree not to act on the current suicidal/homicidal ideation and agrees 100% to keep themselves safe.

If you suspect your child/adolescent is in a manic or hypomanic episode, experiencing psychotic symptoms or becoming extremely physically agitated, contact your treatment team or emergency room immediately. If the person is not actively involved in treatment, local hospitals or mental health clinics are appropriate to contact.

Take seriously all suicidal/homicidal talk or gestures by the person. Remove all available methods, such as firearms and medications. There are emergency procedures that can be utilized to hospitalize the person if they are at immediate risk to harm themselves or others.

**Effective Coping Strategies/Coping with "another episode"**

- Be hopeful-Bipolar Disorder can be treated and prevented.
- Encourage person to remain in treatment.
- Encourage person to take medication as prescribed, even if feeling better. Parents should maintain control of the medication supply.
- Take care of yourself; go on with your life.
- Be direct in communicating.
- Provide feedback about positive changes you noticed.
- Always take suicide talk seriously - let us know.
- Make school aware of what is occurring - they can be supportive. Remember the illness is causing the person's changes - avoid taking angry comments personally.
- Look for gradual improvement.
- Encourage the person to follow through with specific plans or steps, but avoid overprotecting or overdoing for the person.
- Provide a safe environment during manic episodes.
- Get treatment for self if needed.
• Please share information about your child/adolescent's illness with other family members. It does help to understand that the condition is a legitimate illness.

• Please call us with any questions or concerns. Let us know other ways we can provide additional help.

• Share your experiences with other parents. Become involved with local parent support groups.

Bipolar Disorder is a treatable mental illness. Progress in research in all areas related to the various mood disorders has been made and is continuing. Although there remains a lot we do not know yet, we look to the promise of continued research. After having read this manual, you will now be familiar with the basic features, types, and treatment approaches for Bipolar Disorder. We hope you find this information helpful, and we look forward to working with you.
NATIONAL SUPPORT ASSOCIATIONS

National Depressive and Manic-Depressive Association (NDMDA)
730 N. Franklin, Suite 501
Chicago, IL 60610
(312) 642-0049
(800) 826-3632

National Mental Health Information Center
National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
(800) 969-6642
(703) 684-7722

National Institute of Mental Health and the D/ART Program
National Institute of Mental Health
Public Inquiries Branch, Room 7C02
Mail Code 8030
Bethesda, MD 20892
(800) 421-4211
(301) 443-4513

National Alliance for the Mentally Ill (NAMI)
2101 Wilson Boulevard, Suite 302
Arlington, VA 22201
(800) 950-6264

National Mental Health Association
1021 Prince Street
Alexandria, VA 23314-2971
(800) 969-6642

LOCAL SUPPORT ASSOCIATIONS

Stanley Center

Pittsburgh, PA 15213
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